Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS1774AGC	A. BUILDING _____ B. WING _____	06/30/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOYALTON OF LAS VEGAS	3025 E RUSSELL ROAD LAS VEGAS, NV 89120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of a complaint investigation and resurvey conducted in your facility on 6/19/09 and completed on 6/30/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for 105 Residential Facility for Group beds for elderly and disabled persons, residents and provide care to persons with Alzheimer's disease, Category II residents. The census at the time of the survey was 54. Three resident files were reviewed. Complaint #NV00022304 was substantiated. See Tag Y878 and Y925. The following deficiencies were identified:	Y 000		
Y 878 SS=G	449.2742(6)(a)(1) Medication / Change order NAC 449.2742 6. Except as otherwise provided in this subsection, a medication prescribed by a physician must be administered as prescribed by the physician. If a physician orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall:	Y 878		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Y 878	Continued From page 1 (1) Comply with the order. This Regulation is not met as evidenced by: Based on record review and interview on 6/19/09, the facility failed to follow the changed medication orders and give medications as prescribed by a physician to 1 of 3 residents (Resident #1). Findings include: Resident #1 was admitted to the facility on 5/15/08 with diagnoses including chronic obstructive pulmonary disease (COPD), depression, anxiety, coronary artery disease, chronic pain and chronic anemia. The facility assisted the resident with medications prescribed by her physician. On 5/1/09, the resident was ill and transferred to the hospital. She was diagnosed with chronic obstructive pulmonary disease, colitis (inflammation of the colon) and Clostridium difficile, a bacterial infection that causes diarrhea. The resident was in the hospital until 5/25/09 then transferred to a rehabilitation hospital for recovery. The resident returned to the facility on 6/12/09. At the time of the investigation on 6/19/09, the resident had been readmitted to the hospital. Review of Resident #1's Medication Administration Records (MAR) on 6/19/09 revealed when the resident returned to the facility from the rehabilitation hospital; she came with medications prescribed by the hospital's physician. The facility still had the resident's medications from prior to her 5/1/09 hospital admission. The June 2009 MAR indicated from 6/12/09 to 6/15/09, the facility gave the resident	Y 878		

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Y 878	Continued From page 2 her previous medications as well as the new medications ordered by the physician from the rehabilitation facility. There was no documented evidence in the resident file that the facility contacted the resident's care provider for clarification on which medications to give the resident until 6/15/09. The facility's interim executive director (ED) was interviewed on 6/19/09. The ED reported the facility's regional director of quality services (RD) spoke to Resident #1's medical provider on 6/15/09 regarding the resident's medications. The ED revealed the prescriptions from the rehabilitation physician were taken to the resident's care provider and the care provider approved of the list of medications and added two more medications. He stated the RD then notified the pharmacy of the correct medications to be placed on the resident's MAR. The care provider's notes for Resident #1's office visit on 6/15/09 were requested and received on 6/30/09. The care provider's notes revealed he, "spoke multiple time with family, caretakers at the Loyalton and with home health nurse, apparently the Loyalton continued the pts old medications she was taking prior to hospital admission along with d/c meds, pt had been over medicated after review of MARS, Loyalton initially told family members that they did not give her old meds then later admitted to giving her the Rx." A copy of the facility's June 2009 MAR for Resident #1 was given to the care provider to review during the office visit on 6/15/09. The care provider discontinued the following medication: -OxyContin 15 milligrams (mg) twice daily (reduces pain) -Requip 2 mg twice daily (decreases tremors) -Gabapentin 300 mg every eight hours (reduces nerve pain)	Y 878		

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Y 878	Continued From page 3 -Mirtazapine 7.5 mg at bedtime (improves sleeping) -Seroquel 25 mg at bedtime (decreases behaviors) -Bupropion 75 mg every day (elevates mood) -Sertraline 50 mg every day (elevates mood) -Lidoderm 5% patch apply every day on for 12 hours and off for 12 hours (reduces nerve pain) -Lopressor 25 mg twice daily (for high blood pressure) The facility continued to give Resident #1 the Lopressor for two more doses until the resident was transferred to the hospital on 6/17/09. On 6/16/09 at 11:00 PM, Resident #1 had complained of diarrhea and nausea. The resident's daughter requested the facility transfer the resident to the hospital. The emergency room admission report indicated the resident's blood pressure was low, 84/45, and her oxygen saturation was low, 91%, while she received 2 liters of oxygen. The resident remained in the hospital. This was a repeat deficiency from the 6/11/09, 5/28/09, 5/13/09 State Licensure surveys. Severity: 3 Scope: 1	Y 878		
Y 925 SS=G	449.2748(5)(a)(b) Medication / Resident Transfer NAC 449.2748 5. If a resident is transferred to a hospital or skilled nursing facility, the residential facility shall hold the resident's medications until the resident returns or for 30 days after the transfer, whichever is less, unless the hospital or nursing facility requests the residential facility to provide	Y 925		

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Y 925	Continued From page 4 the hospital or skilled nursing facility with the medications. If the resident does not return within 30 days after the transfer, the residential facility shall promptly dispose of any remaining medications. Upon the return of the resident from a hospital or skilled nursing facility, the residential facility shall, if there has been any change in the resident's medication regimen: (a) Contact a physician, within 24 hours after the resident returns, to clarify the change. (b) Document the physician contact in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744. This Regulation is not met as evidenced by: Based on interview and record review on 6/19/09, the facility failed to contact the physician within 24 hours after 1 of 3 residents returned to the facility to clarify medication changes (Resident #1). Findings include: Resident #1 was admitted to the facility on 5/15/08 and the facility assisted the resident with medications prescribed by her physician. On 5/1/09, the resident was ill and transferred to the hospital. The resident was in the hospital until 5/25/09 then transferred to a rehabilitation hospital for recovery. The resident returned to the facility on 6/12/09. Review of Resident #1's Medication Administration Records (MAR) on 6/19/09 revealed when the resident returned to the facility from the rehabilitation hospital; she came with medications prescribed by the hospital's physician. The facility still had the resident's	Y 925		

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Y 925	Continued From page 5	Y 925		

medications from prior to her 5/1/09 hospital admission. The June 2009 MAR indicated from 6/12/09 to 6/15/09, the facility gave the resident her previous medications as well as the new medications ordered by the physician from the rehabilitation facility. There was no documented evidence in the resident file the facility contacted the resident's care provider for clarification on which medications to give the resident until 6/15/09.

The facility's interim executive director (ED) was interviewed on 6/19/09. The ED reported the facility s regional director of quality services (RD) spoke to Resident #1's medical provider on 6/15/09 regarding the resident's medications. The ED revealed the prescriptions from the rehabilitation physician were taken to the resident's care provider and the care provider approved of the list of medications and added two more medications. He stated the RD then notified the pharmacy of the correct medications to be placed on the resident's MAR.

The care provider's notes for Resident #1's office visit on 6/15/09 were requested and received on 6/30/09. The care provider's notes revealed he, "spoke multiple time with family, caretakers at the Loyalton and with home health nurse, apparently the Loyalton continued the pts old medications she was taking prior to hospital admission along with d/c meds, pt had been over medicated after review of MARS, Loyalton initially told family members that they did not give her old meds then later admitted to giving her the Rx."

The facility had two " Event Management Reports " for Resident #1 for alleged falls. The reports indicated that on 6/13/09 at 5:00 PM, the resident was found on the floor between her wheelchair and bed. The resident was given first aid and her physician and family were notified. There was no specific documentation regarding what first aid

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Y 925	Continued From page 6 was provided to the resident. On 6/14/09 at 7:15 PM, the report indicated the resident was observed on the floor. She again received first aid, and her family and physician were notified. There was no specific documentation regarding what first aid was provided to the resident. Resident #1's friend, Resident #2, was interviewed on 6/19/09. Resident #2 related Resident #1 appeared pale and shaky when she returned to the facility from the rehabilitation hospital. Resident #2 reported she saw Resident #1 fall in her bathroom on 6/12/09. There was no documented evidence of a fall on 6/12/09 in the resident's record. Resident #2 reported she had not visited with the resident since 6/12/09. Resident #1's roommate, Resident #3, was interviewed on 6/19/09. Resident #3 recounted seeing Resident #1 fall two times on 6/15/09 while the resident was attempting to get from her bed to her chair. There was no documented evidence of falls on 6/15/09 in the resident's medical record. On 6/16/09 at 11:00 PM, Resident #1 had complained of diarrhea and nausea. The resident's daughter requested the facility transfer the resident to the hospital. The emergency room admission report indicated the resident's blood pressure was low, 84/45, and her oxygen saturation was low, 91%, while she was on 2 liters of oxygen. The resident remains in the hospital. Severity: 3 Scope: 1	Y 925		